TECHNOLOGY ASSISTED WAIVER/EPSDT
NURSING SERVICES PROVIDER

SKILLS CHECKLIST FOR INDIVIDUALS CARING FOR TRACHEOSTOMIZED AND/OR VENTILATOR ASSISTED CHILDREN AND ADULTS

Agency Name _____
Office Location _____
Name of Nurse Providing Service _____

ASSESSMENTS	Experience Yes	No	Date of Most Recent Experience
Breath Sounds – Auscultation:			
Before Suction			
After Suction			
Need for Aerosol			
Signs & Symptoms:			
Respiratory Distress			
Hypoxia			
Side Effects of Medications			
Fluid Retention			

PROCEDURES			
Chest Physical Therapy			
Suctioning:			
Positioning for			
Nasopharyngeal			
Trachea			
Trach Care:			
Clean Trach Site			
Change Trach Ties			
Change Trach Tube			
Cleaning of Inner Cannula			
Place on Trach Collar			
Manual Resuscitation Device Application:			
Via Trach			
Via Mouth			
Emergency Protocol/Procedure:			
Knowledge of Individualized Plan			
Monitoring & Equipment:			
Vital Signs			
Skin Care			
Oral Hygiene			
Use of Apnea/Bradycardia Monitor			
Placement on Oxygen Delivery Device/Trach Collar			

	Experience Yes	No	Date of Most Recent Experience
Monitoring & Equipment (Continued):			
Placement on Ventilator			
Calibrate Oxygen Analyzer			
Check Oxygen Level/Liter Flow/Tank Level			
Check/Calibrate Ventilator Settings			
IMV			
PEEP			
Pressure Units			
Tidal Volume			
Systematic Troubleshooting of Ventilator			
Use of Respirometer			

Humidity System:			
Check Water Level			
Check Temperature			
Filling Procedure			
Draining Water from Tubing			
Cleaning of Humidity Bottles/Cascade			
Check Compressor Operation			
Clean Compressor Unit Screen			
Assess Suction Machine Pressure			
Clean Suction Machine			
Clean Suction Catheters			
Clean Corrugated Tubing			
Clean Manual Resuscitation Device (Reservoir Bag & Assoc. Equip)			
Clean Trach Collar			
Clean Trach Tubes			
Disposable			
Metal			

Medication Administration:			
Administration Technique (as appropriate)			
Installation of Normal Saline			
Administration of Aerosol Treatments			

Additional Individualized Assessments/Skills

_____ _____
_____ _____
_____ _____

I (Supervisor/Designee) _____, have inserviced the individual designated as Orientee regarding assessments and skills listed above.

Initial and Date indicates procedure has been described and/or demonstrated in a competent manner.

I (Orientee) _____, understand all assessments and skills listed above and am able to perform same in a competent and confident manner.

*Please indicate N/A when nonapplicable

SKILLS CHECKLIST FOR NURSES CARING FOR INDIVIDUALS WITH NUTRITIONAL NEEDS

Agency Name _____
Office Location _____
Name of Nurse Providing Service _____

ASSESSMENTS:	Date Describe	Date Demo
Assess and Record Intake and Output		
Assess Signs and Symptoms:		
Dehydration		
Fluid Retention		
Procedures/Techniques:		
Weight		
Skin Care:		
GT Site		
NG Site		
PO (By Mouth) Feeding:		
Preparation of Special Formula/Feeding		

Nasogastric Feeding:

Preparation of Special Formula/Feeding		
Insert NG Tube		
Check NG Placement		
Check NG Residual		
Bolus Feed		
Use of Feeding Pump		

Gastrostomy Feeding:

Insert GT Tube		
Check Placement of GT Tube		
Bolus Feed		
Use of Feeding Pump		

Hyperalimentation (As Per Physicians Orders):

Reading/Checking Hyperalimentation Prescription		
Operation of Infusion Pump		
Troubleshooting of Infusion		
Placement/Care of Infusion Line		

I (Supervisor/Designee) _____, have inserviced the individual designated as Orientee regarding assessments and skills listed above.

Initial and Date indicates procedure has been described and/or demonstrated in a competent manner.

I (Orientee) _____, understand all assessments and skills listed above and am able to perform same in a competent and confident manner.

*Please indicate N/A when nonapplicable